

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

33708

State File No. _____

FILED OCT 2 1952

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>547</u>		Registrar's No. <u>2430</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Richmond Heights</u>				c. LENGTH OF STAY (In this place) <u>6 days</u>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Marys Hospital</u>				e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clayton</u>			
				d. STREET ADDRESS (If rural, give location) <u>6501 Clayton Road</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Brother Justin</u>		b. (Middle) _____		c. (Last) <u>Egan</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 19, 1952</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>May 25, 1889</u>		9. AGE (In years last birthday) <u>63</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Christian Brother</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Thomas P. Egan</u>		13b. MOTHER'S MAIDEN NAME <u>Delia McGinnis</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Brother S. Conrad 6501 Clayton Road</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Haemorrhage into right Cerebral Cortex</u> <u>Cardiomegaly with calcified aortic valve.</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Hydrothorax, right.</u> <u>Basilar pneumonitis bilateral.</u> DUE TO (c) <u>Arteriosclerosis.</u> II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>331X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>9/13/52</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>9/13</u> , 19 <u>52</u> , to <u>9/19/52</u> , 19____, that I last saw the deceased alive on <u>9/18</u> , 19 <u>52</u> , and that death occurred at <u>4:55A m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>[Signature]</u>				23b. ADDRESS <u>634 North Grand</u>		23c. DATE SIGNED <u>9/19/52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9-22-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Glencoe Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Glencoe, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>9-19-52</u>		REGISTRAR'S SIGNATURE <u>Hesbert R. Donke MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Donnelly</u>		ADDRESS <u>3840 Lindell</u>	

52 (Licensed Embalmers' Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

4005

Dr Wade
mo Theatre Bldg
2-3

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me or by me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Licensed Embalmer No. 4699

P. O. Address St Charles, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.